PERSONAL HEALTH

**RECORD**

FOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REMEMBER TO TAKE

YOUR

PERSONAL HEALTH RECORD

WITH YOU

TO ALL DOCTOR VISITS.

My Personal Health Record

PERSONAL INFORMATION

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile/Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile/Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAREGIVER INFORMATION

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile/Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Personal Health Record

PROVIDER INFORMATION

Primary Care Doctor

Telephone

Other Providers

Telephone

Other Providers

Telephone

Home Care Agency

Telephone

Pharmacy

Telephone

Primary Insurance Provider

Telephone

Subscriber ID: Group #:

Supplemental Insurance Provider

Telephone

Subscriber ID: Group #:

My Personal Health Record

MY PERSONAL GOALS

What would I like to do or accomplish over the next week, month and year? List any health, activity and life goals.

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What Do I Need to Do to Reach My Goals?

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My Personal Health Record

RED FLAGS

These are symptoms and drug reactions I need to be able to recognize and know how to handle if they occur.

My Personal Health Record

MEDICAL HISTORY

Please indicate whether you currently experience or have a history of the following medical problems.

****Cancer ****Heart Attack

Type \_\_\_\_\_\_\_\_\_\_\_\_ ****Diabetes,

****High Blood Pressure****Type \_\_\_\_\_\_\_\_\_\_\_\_\_

****Asthma ****Glaucoma

****Congestive Heart****Dementia/

Failure Alzheimer’s

****Stroke ****Anxiety

****Kidney Disease****Former

****High Cholesterol****Current

****Thyroid Problem****Depression

****COPD ****Former

****Bleeding Disorder****Current

****Seizures ****Other \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please indicate whether you have had the following immunizations.

|  |  |  |
| --- | --- | --- |
| ****Tetanus, diphtheria, | ****Influenza (flu) vaccine |  |
| pertussis (Tdap) vaccine |  |
|  |  |
| ****Pneumococcal vaccine | ****Shingles vaccine |  |

My Personal Health Record

RECENT HOSPITALIZATION/ SURGERY/ ER VISITS

Date admitted: \_\_\_\_\_\_ Date discharged: \_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date admitted: \_\_\_\_\_\_ Date discharged: \_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date admitted: \_\_\_\_\_\_ Date discharged: \_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date admitted: \_\_\_\_\_\_ Date discharged: \_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Personal Health Record

MY QUESTIONS FOR MY DOCTOR

Remember to discuss medication questions with your doctor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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MY PRIMARY HEALTH CONCERNS

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My Personal Health Record

**To better manage my health**

**and medications, I can...**

* Take this Personal Health Record with me wherever I go, including all doctor visits and future hospitalizations.
* Call my doctor when I have questions about my medications, or if I would like to change how I take my medications.
* Inform my doctors of **ALL** medications that I take, including over-the-counter drugs, vitamins, supplements and herbal formulas.
* Update my Medication Record with any changes to my medications.
* Know why I am taking each of my medications.
* Know how much, time of day and length of time I am taking **or have taken** each medication.
* Consider using a weekly or monthly medication (pill) organizer.
* Know possible medication side effects to watch out for and what to do if I notice any.

My Personal Health Record

MY DISCHARGE CHECKLIST

Before I leave each facility, the following tasks should be completed

I have been involved in decisions about what will take place after I leave the facility.

I understand where I am going after I leave this facility and what will happen with me once I arrive.

I have the name and telephone number of a person I should contact if a problem arises during my transfer.

I understand what my medications are, how to obtain them and how to take them.

I understand the potential side effects of each medication and whom I should call if I experience any side effects.

I understand what symptoms I need to watch for and whom I should call when I notice them.

I understand how to keep my health problems from intensifying.

My doctor and nurse **have** answered my most important questions prior to my leaving the care facility.

I have scheduled any necessary follow-up appointments with my doctor.

I have transportation to and from this appointment.

My Personal Health Record

ADVANCE CARE DIRECTIVES

Advance Care Directives are written instructions for your family and medical providers about the kind of medical treatment you would want if you became unable to give instructions. An advance directive can also specify one or more persons to make medical decisions for you in the event that you are unable to do so for yourself.

**Do you have an advance care directive: ** Yes **** No

* Living Will **** Five Wishes **** CPR Directive
* Resuscitate **** Do Not Resuscitate
* Medical Power of Attorney: Name/Telephone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of the document(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provide a copy of your advance care directive to your doctor.**

My Personal Health Record

MEDICATIONS & SUPPLEMENTS RECORD

Include over-the-counter drugs, vitamins, herbal formulas and any medications prescribed by a specialist. Update your record every time you add or change a medication or supplement. Do **NOT** black out old medications listed below. Instead, use a single line to cross out old medications so that you and your doctor can still read your medication history. If you are taking your medications differently than prescribed, please discuss your reasons with your doctor.

Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Drug Name** | **It looks like...** |

Brand name, generic name, Color, shape, etc. dose

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How** | **How do I take it?** | **Start** | **Stop** | **Doctor** |
| **many?** | with water, food, etc. | Date | Date | **Name** |
| # of pills |  |  |  |  |

When I wake up, I take…

My Personal Health Record

|  |  |
| --- | --- |
| **Drug Name** | **It looks like...** |

Brand name, generic name, Color, shape, etc. dose

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How** | **How do I take it?** | **Start** | **Stop** | **Doctor** |
| **many?** | with water, food, etc. | Date | Date | **Name** |
| # of pills |  |  |  |  |
|  |  |  |  |  |

In the afternoon, I take…

In the evening, I take…

My Personal Health Record

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Drug Name** | **It looks like...** | **How** | **How do I take it?** | **Start** | **Stop** | **Doctor** |
| Brand name, generic name, | Color, shape, etc. | **many?** | with water, food, etc. | Date | Date | **Name** |
| dose |  | # of pills |  |  |  |  |

Before I go to bed, I take…

Other medicines that I do not take every day…